

**Healthy Families Program
Review Form**



Applicant Information:

Family Member Number:

Name	First: 	Last:
Phone Number	Day Hours: () -	Evening Hours : () -
Mailing Address	Street:	Apt. No.
	City:	State: Zip Code:

Information on Individuals Being Appealed:

Person's Name	First:	Last:	Date of Birth: / /	S.S.N. (optional): - -
Person's Name	First:	Last:	Date of Birth: / /	S.S.N. (optional): - -
Person's Name	First:	Last:	Date of Birth: / /	S.S.N. (optional): - -
Person's Name	First:	Last:	Date of Birth: / /	S.S.N. (optional): - -
Person's Name	First:	Last:	Date of Birth: / /	S.S.N. (optional): - -
Person's Name	First:	Last:	Date of Birth: / /	S.S.N. (optional): - -

Reason(s) for Review (You must respond to numbers 1 through 4; number 5 is optional. Please attach a separate piece of paper if you need more space to write.):

1) Please tell us the decision you would like us to review. (Or, you may include a copy of the letter you received from the Healthy Families Program that indicates the decision you want reviewed.)

2) Please tell us why you disagree with our decision. (You may check one or more boxes below, or explain in writing.)

- ☐ Disagree with income calculations ☐ Did submit birth certificate(s) ☐ Member is not on no-cost Medi-Cal
☐ Disagree that a payment was not made ☐ Did submit immigration document(s)
☐ Other (explain in writing): _____

3A) Do you think our decision violated a law, rule, regulation, or program policy that is printed in the Healthy Families Program application, handbook, or other program materials? ☐ yes ☐ no

3B) If "yes," which one?

4) Please tell us what action you would like us to take.

5) Please tell us if there is any other information you think would help us in reviewing our decision. (You may attach supporting documentation.)

Applicant's Signature:

Date:

- ☐ Please check if documentation is attached.
Please write your Family Member Number
on each document.

Please mail or fax this form to:

Healthy Families Program
Attn: Review Unit
P.O. Box 138005
Sacramento, CA 95813-8005
Fax: 1-866-848-4977

For Use By Healthy Families Program Review Only

Research Analyst Name:

Date Received:

Date Completed: